		FOR BHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036574

Facility Name: Imboden Creek Living Center

Address: 180 West Imboden Place (Number) Decatur (City) 62521 (Zip Code)

County: Macon

Telephone Number: (217) 422-6464 **Fax #** (217) 422-9418

HFS ID Number: 37-1122149

Date of Initial License for Current Owners: 09/08/1980

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Thomas K. Leach **Telephone Number:** (217) 423-6000

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/04 to 9/30/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) John Brinkoetter
(Title) President

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Thomas K. Leach, Member
(Firm Name & Address) Sleeper, Disbrow, Morrison, Tarro & Lively, LLC, P.O. Box 1460, Decatur, IL 62525-1460
(Telephone) (217) 423-6000 Fax # (217) 423-6100

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 10/01/04 Ending: 9/30/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	95	Skilled (SNF)	95	34,675	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	95	TOTALS	95	34,675	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	7,828	17,127	5,241	30,196	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	7,828	17,127	5,241	30,196	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.08%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/08/1990

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 95 and days of care provided 5,013

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 09/30/05 Fiscal Year: 09/30/05

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Imboden Creek Living Center # 0036574 **Report Period Beginning:** 10/01/04 **Ending:** 9/30/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	233,362	27,941	23,513	284,816	50	284,866		284,866			1
2	Food Purchase		237,189		237,189	(37,412)	199,777		199,777			2
3	Housekeeping	131,449	33,209		164,658		164,658		164,658			3
4	Laundry	41,498	22,140		63,638		63,638		63,638			4
5	Heat and Other Utilities			84,465	84,465		84,465		84,465			5
6	Maintenance	51,540	31,231	54,550	137,321		137,321		137,321			6
7	Other (specify):*											7
8	**TOTAL General Services**	457,849	351,710	162,528	972,087	(37,362)	934,725		934,725			8
	B. Health Care and Programs											
9	Medical Director			17,600	17,600		17,600		17,600			9
10	Nursing and Medical Records	1,338,186	82,438	9,445	1,430,069		1,430,069		1,430,069			10
10a	Therapy											10a
11	Activities	53,947	13,866	2,579	70,392		70,392		70,392			11
12	Social Services	26,509		1,604	28,113		28,113		28,113			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,418,642	96,304	31,228	1,546,174		1,546,174		1,546,174			16
	C. General Administration											
17	Administrative	157,947			157,947		157,947		157,947			17
18	Directors Fees											18
19	Professional Services			4,450	4,450		4,450		4,450			19
20	Dues, Fees, Subscriptions & Promotions			22,780	22,780		22,780		22,780			20
21	Clerical & General Office Expenses	27,018	16,335	20,380	63,733		63,733	(14,379)	49,354			21
22	Employee Benefits & Payroll Taxes			359,855	359,855	37,412	397,267		397,267			22
23	Inservice Training & Education			50	50	(50)						23
24	Travel and Seminar			6,389	6,389		6,389		6,389			24
25	Other Admin. Staff Transportation			623	623		623		623			25
26	Insurance-Prop.Liab.Malpractice			76,955	76,955		76,955		76,955			26
27	Other (specify):* Nondeductible exp			27,863	27,863		27,863	(27,863)				27
28	**TOTAL General Administration**	184,965	16,335	519,345	720,645	37,362	758,007	(42,242)	715,765			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,061,456	464,349	713,101	3,238,906		3,238,906	(42,242)	3,196,664			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Imboden Creek Living Center #0036574 **Report Period Beginning:** 10/01/04 **Ending:** 9/30/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			43,079	43,079		43,079	83,988	127,067			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							119,811	119,811			32
33	Real Estate Taxes			87,772	87,772		87,772		87,772			33
34	Rent-Facility & Grounds			498,000	498,000		498,000	(509,786)	(11,786)			34
35	Rent-Equipment & Vehicles			2,170	2,170		2,170		2,170			35
36	Other (specify):*											36
37	**TOTAL Ownership**			631,021	631,021		631,021	(305,987)	325,034			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		149,352	378,255	527,607		527,607		527,607			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,013	52,013		52,013		52,013			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		149,352	430,268	579,620		579,620		579,620			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,061,456	613,701	1,774,390	4,449,547		4,449,547	(348,229)	4,101,318			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Imboden Creek Living Center # 0036574 **Report Period Beginning:** 10/01/04 **Ending:** 9/30/05

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(14,379)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	750	30		9
10	Interest and Other Investment Income	(22,838)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,143)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,900)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(12,716)	27		24
25	Fund Raising, Advertising and Promotional	(11,979)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Page 5A	(125)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (64,330)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(283,899)		34
35	Other- Attach Schedule **Page 5B**	209,034		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (74,865)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (139,195)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Imboden Creek Living Center

ID# 0036574

Report Period Beginning: 10/01/04

Ending: 9/30/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Gifts	$ (125)	27	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(125)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Imboden Creek Living Center **#** 0036574 **Report Period Beginning:** 10/01/04 **Ending:** 9/30/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(14,379)	0	0	0	0	0	0	0	0	0	0	(14,379)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(27,863)	0	0	0	0	0	0	0	0	0	0	(27,863)	27
28	**TOTAL General Administration**	(42,242)	0	0	0	0	0	0	0	0	0	0	(42,242)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(42,242)	0	0	0	0	0	0	0	0	0	0	(42,242)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Imboden Creek Living Center** **# 0036574** **Report Period Beginning:** **10/01/04** **Ending:** **9/30/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	750	83,238	0	0	0	0	0	0	0	0	0	83,988	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(22,838)	142,649	0	0	0	0	0	0	0	0	0	119,811	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(509,786)	0	0	0	0	0	0	0	0	0	(509,786)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(22,088)	(283,899)	0	0	0	0	0	0	0	0	0	(305,987)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(64,330)	(283,899)	0	0	0	0	0	0	0	0	0	(348,229)	45

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 10/01/04 Ending: 9/30/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
John & Martha Brinkoetter	100			Imboden Gardens	Decatur	Assisted Living

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		34	Rent	$ 509,786	John & Martha Brinkoetter	100.00%	$	$ (509,786)	1
2	V		30	Depreciation		John & Martha Brinkoetter	100.00%	83,238	83,238	2
3	V		32	Interest		John & Martha Brinkoetter	100.00%	142,649	142,649	3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 509,786			$ 225,887	$ * (283,899)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 10/01/04 Ending: 9/30/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	John Brinkoetter	President	Administrative	100.00		40	100.00	Salary	$ 32,045	17,7	1
2	Martha Binkoetter	Clerical	Clerical	100.00		40	100.00	Salary	23,072	21,7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 55,117		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 10/01/04 Ending: 9/30/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Imboden Creek Gardents
Street Address: 185 W. Imboden Drive
City / State / Zip Code: Decatur, IL 62521
Phone Number: ((217) 233-1425
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Wages-Cleaning	Days	46,115	2	$ 324	$ 324	30,196	$ 212	1
2	5	Utilities	Days	46,115	2	3,355		30,196	2,197	2
3	6	Supplies-Repairs	Days	46,115	2	665		30,196	435	3
4	6	Repairs & Maintenance	Days	46,115	2	15,235		30,196	9,976	4
5	17	Wages-Administrative	Days	46,115	2	48,939	48,939	30,196	32,045	5
6	19	Professional Services	Days	46,115	2	28,041		30,196	18,361	6
7	20	License & Fees	Days	46,115	2	670		30,196	439	7
8	20	Dues & Subscriptions	Days	46,115	2	20		30,196	13	8
9	21	Wages-Clerical	Days	46,115	2	94,102	94,102	30,196	61,618	9
10	21	Office Supplies	Days	46,115	2	9,093		30,196	5,954	10
11	21	Telephone	Days	46,115	2	5,518		30,196	3,613	11
12	21	Miscellaneous Office	Days	46,115	2	1,200		30,196	786	12
13	22	Payroll Taxes	Days	46,115	2	12,728		30,196	8,334	13
14	22	Employee Insurance	Days	46,115	2	110		30,196	72	14
15	22	Employee Incentives	Days	46,115	2	212		30,196	139	15
16	24	Travel & Seminar	Days	46,115	2	1,583		30,196	1,037	16
17	25	Auto Expense	Days	46,115	2	2,470		30,196	1,617	17
18	26	Insurance	Days	46,115	2	4,396		30,196	2,878	18
19	30	Depreciation	Days	46,115	2	11,237		30,196	7,358	19
20	32	Interest	Days	46,115	2	55,217		30,196	36,156	20
21	33	Real Estate Taxes	Days	46,115	2	6,121		30,196	4,008	21
22	34	Rent	Days	46,115	2	18,000		30,196	11,786	22
23										23
24										24
25	TOTALS					$ 319,236	$ 143,365		$ 209,034	25

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 10/01/04 Ending: 9/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Regions Bank		X	Real Estate Loan	$17,632.00	04/27/01	$ 3,302,473	$ 2,815,357	04/05/09	5.0000	$ 142,649	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Regions Bank		X	Line of Credit		10/12/05	1,000,000	979,000	10/12/06	6.7500	30,130	6
7	Regions Bank		X	Line of Credit		10/1/05	200,000	200,000	10/1/06	6.7500	6,026	7
8												8
9	TOTAL Facility Related				$17,632.00		$ 4,502,473	$ 3,994,357			$ 178,805	9
	B. Non-Facility Related*											
10				Interest Income							(22,838)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (22,838)	14
15	TOTALS (line 9+line14)						$ 4,502,473	$ 3,994,357			$ 155,967	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Imboden Creek Living Center **#** 0036574 **Report Period Beginning:** 10/01/04 **Ending:** 9/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	68,514	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	90,252	2
3. Under or (over) accrual (line 2 minus line 1).	$	21,738	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	70,042	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	91,780	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	77,594	8
	2001	82,554	9
	2002	87,936	10
	2003	88,900	11
	2004	92,669	12

Nursing Home-$85,608.26 x 1.035% x 9/12 = $66,453.41

Corp Office-allocated-$7,061.16 x 9/12 x .65479 = $3,589.05

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Imboden Creek Living Center COUNTY Macon

FACILITY IDPH LICENSE NUMBER 0036574

CONTACT PERSON REGARDING THIS REPORT Martha Brinkoetter

TELEPHONE (217) 422-7150 FAX #: (217) 422-9418

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-12-27-231-008	L 001 D 00 South Franklin Estates	$ 85,608.26	$ 85,608.26
2.	04-12-27-278-010	00000105 W. Imboden Dr	$ 7,061.16	$ 4,623.63
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 92,669.42	$ 90,231.89

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 10/01/04 Ending: 9/30/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,960 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	143,748	1988	$ 111,846	1
2					2
3	TOTALS	143,748		$ 111,846	3

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 10/01/04 Ending: 9/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	95		1990	1990	$ 2,772,947	$	40	$ 69,324	$ 69,324	$ 1,043,658	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sewer Improvements			1991	15,000		20	750	750	11,250	9
10	Landscaping			1992	2,460		10			2,460	10
11	Landscaping - Yard Pad			1992	1,000		10			1,000	11
12	Carpeting			1992	584		10			584	12
13	Decorate Activity Room			1992	852		10			852	13
14	Electrical			1993	2,550		10			2,550	14
15	Carpeting			1993	791		10			791	15
16	Carpeting			1993	747		10			747	16
17	Door			1993	657		10			656	17
18	Rose Garden Fence			1995	2,495	250	10	250		2,475	18
19	Carpeting			1996	1,121	112	10	112		1,084	19
20	Drive & Parking Lot			1996	2,065	207	10	207		1,928	20
21	Concrete Drive Service Doors			1995	2,100	210	10	210		2,083	21
22	Carpeting			1997	29,333	2,933	10	2,933		23,222	22
23	Landscaping			1998	2,387	239	10	239		1,731	23
24	Carpeting			1999	2,258	226	10	226		1,449	24
25	Curtains			1999	937	94	10	94		539	25
26	Landscaping			2000	877	88	10	88		505	26
27	Carpeting			2000	2,321	232	10	232		1,238	27
28	Carpeting			2000	3,981	398	10	398		2,090	28
29	Baseboards for Bathrooms			2000	720	72	10	72		378	29
30	Shower Room Tile			2000	2,954	295	10	295		1,550	30
31	Baseboards for Bathrooms			2000	466	47	10	47		242	31
32	Floor Covering			2000	1,032	103	10	103		515	32
33	New Roof			2000	51,000	5,100	10	5,100		25,925	33
34	Roof Drains			2000	3,691	369	10	369		1,845	34
35	Deck			2000	2,668	267	10	267		1,334	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 10/01/04 Ending: 9/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Tile Installation	2000	$ 1,380	$ 138	10	$ 138	$	$ 724	37
38	Floor Covering	2000	532	53	10	53		266	38
39	Deck & Handrails	2001	27,848	2,785	10	2,785		13,228	39
40	Siding	2000	1,475	148	10	148		739	40
41	Kitchen Floor/Baseboards	2001	8,244	824	10	824		3,434	41
42	Carpeting	2002	1,972		10	129	129	621	42
43	Security System	2002	8,338		8	683	683	3,115	43
44	Outside Door	2002	912		10	60	60	250	44
45	Underground Cable System	2002	9,178		10	601	601	2,972	45
46	Glass Door	2002	1,321		10	86	86	438	46
47	Carpeting	2002	2,732	273	10	273		955	47
48	Dining Room Carpeting	2002	11,734	1,173	10	1,173		3,812	48
49	Fire Alarm System	2002	17,894	1,789	10	1,789		5,367	49
50	Roof	2003	5,250		10	344	344	1,132	50
51	Sprinklers	2003	5,970	597	10	597		1,194	51
52	New Wander Guard System	2003	2,044	204	10	204		408	52
53	Step by Step Floors	2004	2,723	272	10	272		295	53
54	Bathroom	2005	7,245	181	10	181		181	54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,026,786	$ 19,679		$ 91,656	$ 71,977	$ 1,173,812	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 10/01/04 Ending: 9/30/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 430,326	$ 14,654	$ 33,806	$ 19,152	5	$ 288,261	71
72	Current Year Purchases	28,985	2,883	3,100	217	5	3,100	72
73	Fully Depreciated Assets	252,401				5	252,401	73
74								74
75	TOTALS	$ 711,712	$ 17,537	$ 36,906	$ 19,369		$ 543,762	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Staff	1992 Toyota 4 x 4	1996	$ 10,201	$	$	$	5	$ 10,201	76
77	Staff	2001 Ford F150 Truck	2000	35,174	5,863	5,863		5	35,173	77
78	Staff	2001 Lexus LS430	2000	66,573				5	64,653	78
79										79
80	TOTALS			$ 111,948	$ 5,863	$ 5,863	$		$ 110,027	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,962,292	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 43,079	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 134,425	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 91,346	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,827,601	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 10/01/04 Ending: 9/30/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - Related Party
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 2,170 Description: Ice Machine $1,650, Dishwasher $520
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 10/01/04 Ending: 9/30/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39,3 & 39,2	hrs	$	361	$	160,270	$ 697	361	$ 160,967	1
2	Licensed Speech and Language Development Therapist	39,3 & 39,2	hrs		58		26,004		58	26,004	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39,3 & 39,2	hrs		336		191,067		336	191,067	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): Med Supplies, Lab, IV	39,2						149,569		149,569	13
14	TOTAL			$	755	$	377,341	$ 150,266	755	$ 527,607	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Imboden Creek Living Center **#** 0036574 **Report Period Beginning:** 10/01/04 **Ending:** 9/30/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 9/30/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 10,007	$ (3,139)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	993,671	1,071,958	3
4	Supply Inventory (priced at cost)	12,986	20,818	4
5	Short-Term Investments			5
6	Prepaid Insurance	106,655	155,659	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Intercompany	274,863		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,398,182	$ 1,245,296	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	225,924	260,140	15
16	Equipment, at Historical Cost	333,317	645,748	16
17	Accumulated Depreciation (book methods)	(361,662)	(588,902)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Deposits		76,314	22
23	Other(specify): Note Receivable Stockholer		418,920	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 197,579	$ 812,220	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,595,761	$ 2,057,516	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 198,226	$ 242,773	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		50,030	28
29	Short-Term Notes Payable		1,179,000	29
30	Accrued Salaries Payable	31,686	40,642	30
31	Accrued Taxes Payable (excluding real estate taxes)	24,714	31,363	31
32	Accrued Real Estate Taxes(Sch.IX-B)	66,453	166,015	32
33	Accrued Interest Payable		10,302	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Advance Billing	238,787	352,475	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 559,866	$ 2,072,600	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 559,866	$ 2,072,600	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,035,895	$ (15,084)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,595,761	$ 2,057,516	48

***(See instructions.)**

Facility Name & ID Number Imboden Creek Living Center **#** 0036574 **Report Period Beginning:** 10/01/04 **Ending:** 9/30/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 719,219	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 719,219	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	316,676	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 316,676	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,035,895	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 10/01/04 Ending: 9/30/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,752,810	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,752,810	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	11,781	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 11,781	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Memorial Income	1,245	28
28a	Miscellaneous Income	386	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,631	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,766,223	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	972,087	31
32	Health Care	1,546,174	32
33	General Administration	720,645	33
	B. Capital Expense		
34	Ownership	631,021	34
	C. Ancillary Expense		
35	Special Cost Centers	527,607	35
36	Provider Participation Fee	52,013	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,449,547	40
41	**Income before Income Taxes (line 30 minus line 40)****	316,676	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 316,676	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 10/01/04 Ending: 9/30/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,160	2,161	$ 56,848	$ 26.31	1
2	Assistant Director of Nursing	2,080	2,081	39,094	18.79	2
3	Registered Nurses	2,070	2,215	42,297	19.10	3
4	Licensed Practical Nurses	22,226	23,513	364,181	15.49	4
5	CNAs & Orderlies	68,841	71,648	702,237	9.80	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,240	3,242	33,817	10.43	9
10	Activity Assistants	2,768	2,931	20,130	6.87	10
11	Social Service Workers	2,040	2,041	26,509	12.99	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,081	30,508	14.66	13
14	Head Cook					14
15	Cook Helpers/Assistants	26,159	25,103	202,854	8.08	15
16	Dishwashers					16
17	Maintenance Workers	3,613	3,953	51,540	13.04	17
18	Housekeepers	16,880	17,428	131,449	7.54	18
19	Laundry	5,847	6,169	41,498	6.73	19
20	Administrator	2,080	2,081	107,781	51.79	20
21	Assistant Administrator	960	960	14,828	15.45	21
22	Other Administrative	2,161	2,080	35,338	16.99	22
23	Office Manager					23
24	Clerical	2,362	2,362	27,018	11.44	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,962	2,044	19,728	9.65	31
32	Other Health Ca Restorative	5,945	6,343	77,087	12.15	32
33	Other(specify) Care Plan Coordin	2,080	2,081	36,714	17.64	33
34	TOTAL (lines 1 - 33)	177,554	182,517	$ 2,061,456 *	$ 11.29	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	570	$ 23,513	1,3	35
36	Medical Director	144	17,600	9,3	36
37	Medical Records Consultant	24	3,000	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	48	150	10,3	39
40	Physical Therapy Consultant	111	6,195	10,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,554	11,3	44
45	Social Service Consultant	24	1,604	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	945	$ 53,616		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 10/01/04 Ending: 9/30/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rhonda Falk	Administrator		$ 107,781
Cindy See	Asst Admin		14,828
Diane Hunt	Human Resources		35,338
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 157,947

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
BKD, LLP	Medicare Consultants	$ 150
BKD, LLP	Medicare Cost Report Fee	4,300
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 4,450

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 95,918
Unemployment Compensation Insurance	41,351
FICA Taxes	162,874
Employee Health Insurance	54,583
Employee Meals	37,412
Illinois Municipal Retirement Fund (IMRF)*	
Innoculations	978
Incentives	10,429
Other	276
Uniforms	1,991
TOTAL (agree to Schedule V, line 22, col.8)	$ 405,812

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	9,252
Health Care Worker Background Check	
(Indicate # of checks performed 162)	2,340
Licenses	1,035
IL Health Care Assocation	4,982
Internet Subscriptions	3,137
Dues & Subscriptions	2,486
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,232

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,102
Seminar Expense	4,287
Allocated In-State Travel & Seminar	1,037
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,426

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Imboden Creek Living Center # 0036574 Report Period Beginning: 10/01/04 Ending: 9/30/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number **Imboden Creek Living Center** **#** **0036574** **Report Period Beginning:** **10/01/04** **Ending:** **9/30/05**

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Health Care Assoc. $4,982**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **15,475** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **52,013**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **37,412** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **.4%**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

STATE OF ILLINOIS

Living Centers, Inc. D/B/A Imboden Creek Living Center

ID# 0036574

Report Period Beginning: 10/1/2004

Ending: 9/30/2005

	ALLOCATION OF INDIRECT COSTS	Amount	Sch. V Line Reference	
1	Wages-Cleaning	$ 212	3	1
2	Utilities	2,197	5	2
3	Supplies-Repairs	435	6	3
4	Repairs & Maintenance	9,976	6	4
5	Wages-Administrative	32,045	17	5
6	Professional Servces	18,361	19	6
7	License & Fees	439	20	7
8	Dues & Subscriptions	13	20	8
9	Wages-Clerical	61,618	21	9
10	Office Supplies	5,954	21	10
11	Telephone	3,613	21	11
12	Miscellaneous Office	786	21	12
13	Payroll Taxes	8,334	22	13
14	Employee Insurance	72	22	14
15	Employee Incentives	139	22	15
16	Travel & Seminar	1,037	24	16
17	Auto Expense	1,617	25	17
18	Insurance	2,878	26	18
19	Depreciation	7,358	30	19
20	Interest Expense	36,156	32	20
21	Real Estate Taxes	4,008	33	21
22	Rent	11,786	34	22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	209,034		49